

§ 414.335

this section, Medicare pays for support services only under the prospective payment rates established in § 413.170 of this chapter.

(2) *Exceptions.* If the patient elects to obtain home dialysis equipment and supplies from a supplier that is not an approved ESRD facility, Medicare pays for support services, other than support services furnished by military or VA hospitals referred to in paragraph (a)(2)(iii)(B) of this section, under paragraphs (b)(2)(i) and (ii) of this section but in no case may the amount of payment exceed the limit for support services in paragraph (c)(1) of this section:

(i) For support services furnished by a hospital-based ESRD facility, Medicare pays on a reasonable cost basis in accordance with part 413 of this chapter.

(ii) For support services furnished by an independent ESRD facility, Medicare pays on the basis of reasonable charges that are related to costs and allowances that are reasonable when the services are furnished in an effective and economical manner.

(c) *Payment limits—(1) Support services.* The amount of payment for home dialysis support services is limited to the national average Medicare-allowed charge per patient per month for home dialysis support services, as determined by HCFA, plus the median cost per treatment for all dialysis facilities for laboratory tests included under the composite rate, as determined by HCFA, multiplied by the national average number of treatments per month.

(2) *Equipment and supplies.* Payment for home dialysis equipment and supplies is limited to an amount equal to the result obtained by subtracting the support services payment limit in paragraph (c)(1) of this section from the amount (or, in the case of continuous cycling peritoneal dialysis, 130 percent) of the national median payment as determined by HCFA that would have been made under the prospective payment rates established in § 413.170 of this chapter for hospital-based facilities.

(3) *Notification of changes to the payment limits.* Updated data are incorporated into the payment limits when the prospective payment rates established at § 413.170 of this chapter are up-

42 CFR Ch. IV (10–1–99 Edition)

dated, and changes are announced by notice in the FEDERAL REGISTER without a public comment period. Revisions of the methodology for determining the limits are published in the FEDERAL REGISTER in accordance with the Department's established rulemaking procedures.

[57 FR 54187, Nov. 17, 1992]

§ 414.335 Payment for EPO furnished to a home dialysis patient for use in the home.

(a) Payment for EPO used at home by a home dialysis patient is made only to either a Medicare approved ESRD facility or a supplier of home dialysis equipment and supplies.

(b) Payment is made in accordance with the rules set forth in § 413.170 of this chapter.

[56 FR 43710, Sept. 4, 1991]

Subparts F–H—[Reserved]

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

Subpart A—General Provisions

Sec.

415.1 Basis and scope.

Subpart B—Fiscal Intermediary Payments to Providers for Physician Services

415.50 Scope.

415.55 General payment rules.

415.60 Allocation of physician compensation costs.

415.70 Limits on compensation for physician services in providers.

Subpart C—Part B Carrier Payments for Physician Services to Beneficiaries in Providers

415.100 Scope.

415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers.

415.105 Amounts of payment for physician services to beneficiaries in providers.

415.110 Conditions for payment: Medically directed anesthesia services.

415.120 Conditions for payment: Radiology services.